Government of Newfoundland and Labrador
Department of Health and Community Services
Medical Services Division
mcp

Transition-Related Surgery
Request for Prior Approval

Clinical Eligibility for TRS
To be completed by a physician or nurse practitioner

1. Patient Name (as it appears on the MCP card): _____

MCP: _____

2. Physician or Nurse Practitioner Contact Information:

Name: _____

Provider ID # (if applicable) _____

Address: _____

Phone Number: (____) _____ Fax Number: (___) _____

4. Referring Physician or Nurse Practitioner Professional Declaration:

PRIMARY CLINICAL CRITERIA

I have verified that the patient has:

- Persistent, well-documented gender dysphoria. **Yes / No**
- Capacity to make a fully informed decision and to consent for treatment: **Yes / No**
  - Understands the procedure(s); **Yes / No**
  - Understands the associated risk(s) and complications. **Yes / No**
- Reasonably well-controlled medical or mental health concerns, if present. **Yes / No**
- Has an aftercare / follow-up plan **Yes / No**

SPECIFIC CLINICAL CRITERIA

Breast or Chest Surgery (mastectomy with chest masculinization, breast augmentation). Requires one surgical readiness assessment completed by a mental health professional who has also completed the attached Surgical Readiness Assessor Certification and Recommendation form.

- For breast augmentation, breast aplasia (no breast development) after 12 continuous months of hormone Therapy. **Yes / No / NA**

Genital Surgery: Hysterectomy, Salpingo-oophorectomy, Orchiectomy. Requires two surgical readiness assessments with two attached Surgical Readiness Assessor Certification and Recommendation forms.

- Twelve continuous months of hormone replacement therapy as appropriate to the patient's gender identity (unless contraindicated). **Yes / No / NA**

Genital Reconstructive Surgery: Metoidioplasty, Phalloplasty, Vaginoplasty. Requires two surgical readiness assessments with two attached Surgical Readiness Assessor Certification and Recommendation forms.

- Twelve continuous months of hormone replacement therapy as appropriate to the patient's gender identity (unless contraindicated) **and** 12 continuous months of living in a gender expression that is congruent with their gender identity. **Yes / No / NA**

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Patient MCP: _____

ADDITIONAL CLINICAL CRITERIA

- The patient is physically healthy. **Yes / No**
- There are physical health problems that may contraindicate or complicate the proposed surgery. **Yes / No**
- The patient is psychologically prepared for surgery. **Yes / No**
- The patient has realistic goals and expectations of the surgery. **Yes / No**
- The patient is informed of and understands any alternative procedures. **Yes / No**
- The patient has engaged in a responsible way with the assessment/treatment process. **Yes / No**
- The patient has an adequate support network. **Yes / No**
- The gender identity of the individual has remained stable over time. **Yes / No**
- The patient has regular visits with a health care provider. **Yes / No**

5. Please use the space provided below to include any additional information which you may consider relevant to this Request for Prior Approval. For example, you may wish to offer further details on the patient's experience of gender dysphoria or transition, on expectations for surgery, coping strategies, living situation or housing, etc.

6. Proposed procedure(s) for which prior approval is requested:

_____

(Please see list of insured TRS procedures, Appendix B)

7. Proposed facility and surgeon for which prior approval is requested:

_____

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8. Referring Physician / Nurse Practitioner Declaration

- I have verified that the patient is a permanent resident of Newfoundland and Labrador and possesses a valid MCP card. **Yes / No**
- I have enclosed:
  - The Patient Information Sheet (completed and signed by the patient). **Yes / No**
  - One surgical readiness assessment and a signed Surgical Readiness Assessor Certification and Recommendation form (for patients recommended for breast or chest surgery). **Yes/No/NA**
  - Two surgical readiness assessments and two signed Surgical Readiness Assessor Certification and Recommendation forms (for patients recommended for genital surgery). **Yes / No/ NA**

9. Certification and Recommendation signature

- I certify that the information given on this form is complete and accurate.
- I recommend this client for Transition-Related Surgery.

Patient's Name (as it appears on the MCP card):_____

Patient's MCP_____

Name of Physician or Nurse Practitioner: _____

Physician/Nurse Practitioner Signature: _____ Date: _____

All information is collected under the authority of Part IV of the *Personal Health Information Act* for the purposes of approving transition-related surgery. For questions on how your information shall be collected, used and disclosed, please contact the Manager of Privacy and Information Security at 709-729-7010.